Maternal Health Intake

Client ID: _____

Admission ID: _____

Client's name *(first, middle, last)*: _____ Maiden name: _____

Client alias: _____ Alias Client ID: _____

ID Number	ID Type

Birth date: ____/____/____ Medicaid ID: _____ Other IDs:

Street address: _____ Apt# _____ County: _____

City: _____ State: _____ Zip code: _____

Cell phone: _____ Alternate phone: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Primary Race: *(enter option from race table below)* _____

Race:

(Check all that apply)
☐ American Indian/Alaska Native
☐ Asian
☐ Black
☐ Native Hawaiian/Other Pacific
☐ White
☐ unknown
☐ other
specify _____

Is participant of Hispanic/Latino descent? ☐ yes ☐ no

Country of Origin: *(if Hispanic/Latino)*

☐ Central America ☐ Mexico ☐ South America ☐ other
☐ Cuba ☐ Puerto Rico ☐ Unknown specify _____

Ethnicity:

☐ African American
☐ African (not Sudanese)
☐ African (Sudanese)
☐ American
☐ Asian (other)
☐ Asian (Burmese)
☐ Asian (Vietnamese)
☐ Bosnian
☐ Chinese
☐ Croatian
☐ Haitian
☐ Hispanic/Latino
☐ Jamaican
☐ Korean
☐ Micronesian
☐ Somalian
☐ unknown
☐ other
specify _____

Languages spoken:

☐ American Sign Language ☐ English ☐ Sudanese ☐ other
☐ Bosnian ☐ Serbian ☐ Vietnamese specify _____
☐ Chinese ☐ Spanish ☐ unknown

Is English the primary language? ☐ yes ☐ no ☐ unknown

Is a translator needed? ☐ yes ☐ no ☐ unknown If yes, what language? _____

Date of contact: _____

How did client hear of services? *(choose all that apply)*

☐ birthright
☐ education/school/AEA
☐ family planning
☐ friend/relative
☐ medical clinic
☐ other participant
☐ primary care provider
☐ school nurse/counselor
☐ shelter
☐ walk-in /self-referral
☐ WIC
☐ unknown
☐ hospital (specify) _____
☐ other (specify)_____

Will services be provided? ☐ yes ☐ no

Program Assigned: ☐ Maternal Health ☐ Oral Health Only ☐ Postpartum Only ☐ Women's Health

If no, reason not served:

☐ eligibility guidelines not met ☐ not pregnant ☐ other
☐ out of service area ☐ services refused specify _____

Client consent form signed? ☐ yes ☐ no Date signed: _____/_____/_____

Subcontractor assigned: _____County Assigned_____

Client Name: _____ Birth Date: _____Medicaid ID: _____

Primary Payment Source: *(enter option from payment source table below)* _____

Secondary Payment source: *(check all that apply)*

☐ Medicare ☐ private insurance ☐ uninsured
☐ Medicaid/Title XIX ☐ self-pay/sliding scale ☐ other specify _____
☐ presumptive eligibility ☐ Title V

WIC certified at admission? ☐ yes ☐ no ☐ unknown

Employment: ☐ full time ☐ part time ☐ unemployed

Current marital status:

☐ divorced ☐ separated ☐ widowed
☐ married ☐ single ☐ unknown

Highest grade participant completed:

☐ 8th grade or less ☐ high school graduate ☐ college degree
☐ 9th grade ☐ GED ☐ technical training
☐ 10th grade ☐ some college ☐ other
☐ 11th grade

How many children does client have? _____ Age range of children: _____

How many children are living in the home? _____

Father Information

Record name of baby's father and choose the code from the tables below to indicate race, ethnicity, relationship and insurance status. If the father's name is not available enter "unknown".

Name:_____

Race:

☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific ☐ other
☐ Asian ☐ White specify _____
☐ Black ☐ unknown

Ethnicity:

☐ African American ☐ Asian (Burmese) ☐ Haitian ☐ Somalian
☐ African (not Sudanese) ☐ Asian (Vietnamese) ☐ Hispanic/Latino ☐ unknown
☐ African (Sudanese) ☐ Bosnian ☐ Jamaican ☐ other
☐ American ☐ Chinese ☐ Korean specify _____
☐ Asian (other) ☐ Croatian ☐ Micronesian

Relationship: ☐ spouse ☐ significant other ☐ other relative ☐ other

Living with participant? ☐ yes ☐ no ☐ unknown

Involved with pregnancy/child? ☐ yes ☐ no ☐ unknown

Employed? ☐ yes ☐ no ☐ unknown

Comments:_____

_____

_____

Previous Pregnancies

Last pregnancy end date: ____/____/____

How many previous pregnancies? _____

How many live births? _____

How many fetal deaths? _____ How many neonatal deaths? _____

How many spontaneous abortions? _____ How many therapeutic abortions? _____

Client Name: _____ Birth Date: _____Medicaid ID: _____

Pregnancy Information

Has the client been seen at any other agency with this pregnancy? ☐ yes ☐ no ☐ unknown

Was this a planned pregnancy? ☐ yes ☐ no ☐ unknown

Was client using birth control? ☐ yes ☐ no ☐ unknown

Birth control type:

☐ birth control pills	☐ natural family planning	☐ ring
☐ condom	☐ Nexplanon	☐ three month injection (Depo)
☐ IUD	☐ patch	☐ none
		☐ other specify _____

Due date _____/_____/_____ Date of last menses _____/_____/_____

When was pregnancy first identified? ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ unknown

Is client receiving prenatal care? ☐ yes ☐ no ☐ unknown

When was first care received? ☐ pre conception ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ no care

Provider's name: _____

Is client taking prenatal vitamins, including folic acid? ☐ yes ☐ no ☐ unknown

Maternal Health and Risk Assessment

Allergies? ☐ yes ☐ no ☐ unknown Specify:_____

Is client taking regular medications? ☐ yes ☐ no ☐ unknown

What medications?

☐ antibiotics	☐ anti seizure meds	☐ other
☐ antidepressants	☐ pain meds	specify _____

Smoke cigarettes? ☐ yes ☐ no ☐ unknown

How many cigarettes per day?

☐ <1	☐ 5-10	☐ 1 pack	☐ more than 2 packs
☐ 1-5	☐ 10-20	☐ 1-2 packs	☐ unknown

Has the client used alcohol in the three months prior to pregnancy? ☐ yes ☐ no ☐ unknown

Is the client currently using alcohol? ☐ yes ☐ no ☐ unknown

How often? ☐ never ☐ less than 1 drink/week ☐ 2-6 drinks/week ☐ 1 drink/day ☐ more than 1 drink/day

Has the client used illicit drugs in the three months prior to pregnancy? ☐ yes ☐ no ☐ unknown ☐ client declines

Is the client currently using illicit drugs? ☐ yes ☐ no ☐ unknown ☐ client declines

What drugs?

☐ cocaine	☐ crank	☐ marijuana	☐ unknown
☐ crack	☐ heroin	☐ methamphetamine	☐ other specify _____

Does client have STDs or a history of STDs? ☐ yes ☐ no ☐ unknown ☐ client declines

What STDs?

☐ chlamydia	☐ hepatitis	☐ syphilis	☐ other specify _____
☐ cytomegalovirus	☐ herpes	☐ trichomonas	
☐ gonorrhea	☐ HPV	☐ unknown	

Is client being treated for STDs? ☐ yes ☐ no ☐ unknown ☐ client declines

Is partner being treated for STDs? ☐ yes ☐ no ☐ unknown ☐ client declines

Client Name: _____ Birth Date: _____Medicaid ID: _____

Was client screened for domestic violence? ☐ yes ☐ no ☐ unknown

Was client screened for substance abuse? ☐ yes ☐ no ☐ unknown

Was client screened for depression? ☐ yes ☐ no ☐ unknown

Oral Health Information

Does client have regular dentist? ☐ yes ☐ no ☐ unknown Name of dentist: _____

When was last dentist visit? ☐ Within 1 year ☐ 1-3 years ago ☐ More than 3 years ago ☐ Never seen a dentist ☐ Unknown

Barrier(s) to dental care:

☐ Cost ☐ Office hours ☐ Other (specify)_____
☐ Dentist will not accept Medicaid ☐ Fear
☐ Transportation ☐ None

Dental payment source:

☐ Medicaid/Title XIX ☐ self-pay/sliding scale ☐ other specify _____
☐ presumptive eligibility ☐Title V
☐ private dental insurance ☐ uninsured

Does client have any oral concerns or problems? ☐ yes ☐ no

If yes, specify: _____

Dental comments: _____

General comments: _____

Intake form completed by:		
Data entered by:		
Quality assurance inspection:		